Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $8,338.40 for dates of service 04/12/01 through 07/13/01.

   b. The request was received on 02/25/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and undated Letter Requesting Dispute Resolution
   b. HCFA(s)-1500
   c. EOB(s)
   d. Letter to Compliance and Practice dated 02/22/02
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution dated 04/26/02
   b. HCFA(s)-1500
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/23/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 04/25/02. The response from the insurance carrier was received in the Division on 05/08/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in undated correspondence, "The documentation to support the work hardening being denied is attached for your review….Each date of service is provided with the documentation attached for daily progress in the program."

2. Respondent: The respondent representative states in correspondence dated 04/26/02, "Carrier denied payment for the DOS in question because the documentation provided failed to substantiate the need for the services billed, work hardening, or that it was performed in accordance with the treatment guidelines, *e.g.*, that it was multi-disciplinary, one-on-one, etc."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 04/12/01 and extending through 07/13/02.

2. The provider submitted EOB(s) that included denial codes of "*00140 RE-EVALUATION" and "*00126 REPORT SUBMITTED DOES NOT APPEAR TO."

3. The carrier provided TWCC 62 forms with the denial codes of:
"F – FEE GUIDELINE MAR REDUCTION";
"97750 – * START/STOP 1:00 – 4:00 DOCUMENTATION SUPPORTS 3 HRS NOT 5."
"N – NOT APPROPRIATELY DOCUMENTED REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED";
"T – NOT ACCORDING TO TREATMENT GUIDELINES RECODE AND RESUBMIT FOR AUDIT SURGERY GR IE (4C); CODE IS 62289";
"T – NOT ACCORDING TO TREATMENT GUIDELINES INCLUDED IN ANOTHER BILLED PROCEDURE RADIOLOGY GR I (D); AMERICAN ACADEMY FOR ORTHOPEDIC SURGEONS GLOBAL DATA; "

   The carrier submitted TWCC 62 forms for all dates of service, but the only audits completed prior to the submission of request for medical dispute resolution are for dates of service 04/12/01, 06/01/01, 06/29/01, and 07/13/01. The TWCC 62 form audit dates for dates of service 04/17/01 through 05/25/01 were performed after the submission of the request for medical dispute. The provider submitted a letter to Compliance and Practices dated 02/22/02 stating, "The carrier failed to respond to the attached submitted request for reconsideration claims within 28 days…" The TWCC 62 forms for dates of service 04/17/02 through 05/25/02 (CPT codes 97545-WH and 97546-WH) are denied by "D – DENIAL AFTER RECONSIDERATION N- NOT APPROPRIATELY DOCUMENTED RE-EVALUATION NO ADDITIONAL RECOMMENDED ALLOWANCE REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED. PER MEDICAL GR. II. E. WORK HARDENING

DOP SHOULD SUPPORT INTERDISCIPLINARY TEAM, WORK STIMULATION SPECIFIC TO THE CLAIMANT'S JOB, AND HOW BEHAVIORAL NEEDS ARE BEING MET." On the provider's Table of Disputed Services for dates of services 04/17/02 through 05/25/02, the provider states, "Documentation to support Svcs were attached to billing on original submissions and Request for Reconsideration. No response for Reconsideration." In a partial copy of a letter faxed on 04/22/02 labeled "Dispute ResolutionFaxes", the provider states, "The documentation to support the work hardening being denied is attached for your review. Our work hardening program complies with an interdisciplinary program as outlined in the TWCC 1996 Medical Fee Guidelines pages 37 – 39. The program is supervised by the treating doctor and a licensed professional physical therapist, which is employed by the physician. Our program is also staffed with a licensed professional counselor, who performs an initial evaluation before entering entering the program, group therapy, and/or individual therapy if needed. Each date of service is provided with the documentation attached for daily progress in the program. The documentation is sufficient in documenting the time work hardening was performed, The patient's reported pain level, systematic work related exercises performed, an Assessment, and plan of treatment. Also, attached are the notes from the LPC regarding treatment during the work hardening program." Because of these particular notes, the Medical Review Officer determined that the provider did know that the work hardening program was denied because of the lack of documentation to support the level of services, therefore, "N – NOT APPROPRIATELY DOCUMENTED REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE
LEVEL OF SERVICE BILLED. PER MEDICAL GR. II. E. WORK HARDENING DOP SHOULD SUPPORT INTERDISCIPLINARY TEAM, WORK STIMULATION SPECIFIC TO THE CLAIMANT'S JOB, AND HOW BEHAVIORAL NEEDS ARE BEING MET." will be used as the denial code for dates of service 04/17/02 through 05/25/02.

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
04/12/01	97750-FCE	$975.00	$300.00	F,N	$100.00 per hr.	MFG MGR (I) (E) (2); CPT descriptor	"FCEs shall be reimbursed at $100.00 per hour for a maximum of five hours ($500.00) for the initial and two hours ($200.00) for an interim and/or discharge test….Required documentation includes the start and end time." The 4-12-01 documents "Start: 4/12/01 1:00:00 AM" and "End: 4/1201 4:00:00 AM" as the start and end times. Provider has failed to document start and stop times in accordance with MFG requirements. The documented time is 3 hours, therefore, **no** additional reimbursement is recommended.

04/17/01 04/17/01 04/18/01 04/18/01 04/19/01 04/19/02 04/20/02 04/20/02 04/23/02 04/23/02 04/24/02 04/24/02 04/26/02 04/26/02 04/27/02 04/27/02 04/30/02 04/30/02 05/01/02 05/01/02 05/02/02 05/02/02 05/03/02 05/03/02 05/15/02 05/15/02 05/17/02 05/17/02 05/18/02 05/18/02 05/21/02 05/21/02 05/22/02 05/22/02 05/24/02 05/24/02 05/25/02 05/25/02	97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH	$102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $204.80 $102.40 $204.80 $102.40 $204.80 $102.40 $204.80 $102.40 $204.80 $102.40 $153.60 $102.40 $307.20 $102.40 $307.20 $102.40 $307.20 $102.40 $307.20	$0.00 for all dates of service	N	$64.00 an hour less 20% = $51.20	MFG MGR (II) (A) (C); (E); STG Rule 134.1001 (e) (2) (A) (L) and (3) (D); CPT descriptor	"The Commission recognizes the need for injured workers to participate in established programs in order to restore function and reduce pain….All services performed by the interdisciplinary core team and other services as part of the program shall be inclusive in the reimbursement of the program." "If the interdisciplinary program is not accredited, then the hourly reimbursement for the program shall be reduced 20% below the maximum allowed reimbursement. If the MAR is listed in the ground rules….This ground rule applies to the interdisciplinary programs which are Work Hardening…" A work hardening program is a highly structured, goal-oriented, individualized treatment program designed to maximize the ability of the persons served to return to work. "Work Hardening programs are interdisciplinary in nature with the capability of addressing the functional, physical, behavioral, and vocational needs of the injured worker. Work Hardening provides a transition between management of the initial injury and return to work while addressing the issues of productivity, safety, physical tolerances, and work behaviors." Work Hardening programs use real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks. These activities are used to progressively improve the biomechanical , neuromuscular, cardiovascular/metabolic, behavioral, attitudinal, and vocational functioning of the persons served. The MFG states "Work Hardening programs use real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks." The STG states "...work hardening program goals should be tailored to physical demands required by job specificity" and "...should show objective substantive and continued improvement over time that correlated to the job description the injured employee will most likely enter upon completion of the program." In comparing the initial FCE dated 04/12/01 and the discharge FCE dated 06/04/01, the "**RESULT"** categories were the same except under "Major Limiting Factors" on the FCE of 06/04/01 stated "PAIN AND APPREHENSIVE". The 04/12/01 FCE states, "PAIN" under the same heading. Both FCE(s) note "**NO**" under the "Return to Work" category for both the initial and the discharge FCE(s). The provider did not submit a treatment plan for the claimant. The initial FCE made recommendations, but no treatment plan. The HCP failed to submit documentation of the claimant's job requirements prior to injury. Therefore, it is unclear how this work hardening program is "tailored to physical demands required by job specificity." as well as correlates "...to the job description the injured employee will most likely enter upon completion of the program." as required in the STG. There is no documentation to support what type of work of simulation was performed. A job analysis was not completed on the claimant. Each daily note begins with the sentence, "Pt performed (blank) hours of work hardening…", but each hour of activity is not documented, therefore, there is no way to determine the level of service to be reimbursed for each hour billed.

							Each daily note assesses the claimant's performance of the day, but the assessment notes do not objectively measure and demonstrate functional gains. The claimant's pain level on 04/17/01 was 7 on a scale of 1 to 10; 04/20/01 8/10; 04/30/01 4/10; 05/17/01 7/10; 05/25/01 6/10 For the most part, the claimant's exercises varied little each day. There is no documentation that the program was administered by an interdisciplinary team. The daily notes listed a "LPTA" and a "MSPT". There are no weekly progress notes or reviews of the claimant's progress. There are no notes which involve other interdisciplinary team members, including the doctor. The areas of behavioral management and vocational needs are not addressed in the documentation submitted by the provider, even though the provider stated in a letter submitted with the dispute that the notes from a LPC were attached. No LPC notes were included with the request for dispute. The work hardening program does not meet the criteria to support the level of service of a work hardening program. **No** reimbursement is recommended.
04/16/01 04/16/01 05/07/01 05/07/01 05/08/01 05/08/01 -5/10/01 05/10/01	97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH 97545-WH 97546-WH	$165.00 $140.00 $165.00 $280.00 $165.00 $280.00 $165.00 $280.00	$0.00 for all dates of service	N	$64.00 an hour less 20% = $51.20	Rule 133.1 (a) (3) (E) (i); Rule 133.305 (e) (1) (D); CPT descriptor	Per Rule 133.1, a complete medical bill includes: "legible supporting documentation…for…interdisciplinary programs such as…work hardening…" Per Rule 133.305, all requests shall include, "a copy of medical records, clinical notes,…,treatment plans, and other documents relevant to the dispute;" The provider failed to submit medical documentation for referenced dates of services. **No** reimbursement is recommended.

06/01/01 06/29/01 07/13/01	62282 62282 62282	$675.00 $675.00 $675.00	$0.00 $0.00 $0.00	T T T	$400.00	STG Rule 134.1001 (e) (3) (G); Advisory 97-01 page 3 Surgery Ground Rules, Section I(e)(4)(c), Surgical Injections page 66; Rule 133.1 (a) (3) (C); CPT descriptor	The STG Rule (e) (2) (T) states, "…The frequency of injections should be limited to one to three injections spaced minimally seven to 14 days apart….Repeat injections after the initial injection and/or series would not be indicated if the initial injection did not prove significant and long term documented relief." STG Rule 134.1001 (e) (3) (G) reports, "Documentation for…spinal injections should show objective/quantified measures of substantive and continued improvement over time which may include but are not limited to: (i) decreased used of medications; (ii) increased function due to reduction in pain; or (iii) enhances the ability of the employee to return to or retain employment." The provider failed to medically document significant or long term relief, decreased use of medications, increased function due to reduction in pain, or enhanced ability for the employee to return to work. There is no documentation of the claimant's work status or pain status. The daily work hardening notes post injections make no mention of the injections or any results from the injections. Advisory 97-01 (see referenced page and section) states, "The phrase 'for lumbar or caudal epidural area' was omitted from the end of the sentence. As corrected it reads: 'Epidural steroid injections shall be billed using code 62289 only for lumbar or caudal epidural areas.' When an epidural steroid injection is performed outside of the lumbar or caudal areas, the appropriate CPT Code should be used describing the service performed." The procedure for each date of service is listed as "Lumbar epidural steroid injection", therefore, the provider coded the procedure incorrectly per Rule 133.1. **No** reimbursement is recommended.
06/01/01 06/29/01	J0704 J0704	$20.00 $20.00	$0.00 $0.00	T T	DOP DOP	STG Rule 134.1001 (e) (2) (A) (i); Rule 133.1 (a) (a) (3) (B); Rule 133.305 (e) (1) (B)	Per Rule 133.1 the provider's medical bill is on a Commission-prescribed form and includes the information required by the form. Rule 133.05 states all requests shall include, "a copy of all medical bill(s) relevant to the dispute, as originally submitted to the insurance carrier for reimbursement…" The provider failed to submit HCFA(s) for J0704 for $20.00 for referenced dates of service. **No** reimbursement is recommended.
06/01/01	72220-WP	$160.00	$0.00	T,G	$51.00	STG Rule 134.1001 (e) (2) (A) (i); CPTdecriptor	STG Rule 134.1001 (e) (2) (A) (i) states, "…treatment of a work related injury must be: adequately documented…" The provider submitted an X-ray report for date of service, but the report failed to meet the criteria of the CPT descriptor. The report detailed another procedure. **No** reimbursement recommended.

06/01/01 06/29/01 07/13/01	76000-WP 76000-WP 76000-WP	$300.00 $300.00 $300.00	$0.00 $0.00 $0.00	T,G T,G T,G	$110.00 $110.00 $110.00	STG Rule 134.1001 (e) (2) (A) (i); (e) (3) (G)	STG Rule 134.1001 (e) (2) (A) (i) states, "…treatment of a work related injury must be: adequately documented…" STG Rule 134.1001 (e) (3) (G) reports, "Documentation for…spinal injections should show objective/quantified measures of substantive and continued improvement over time which may include but are not limited to: (i) decreased used of medications; (ii) increased function due to reduction in pain; or (iii) enhances the ability of the employee to return to or retain employment." The provider failed to medically document significant or long term relief, decreased use of medications, increased function due to reduction in pain, or enhanced ability for the employee to return to work. There is no documentation of the claimant's work status or pain status. The daily work hardening notes post injections make no mention of the injections or any results from the injections. As a result, the ESI procedure did not meet the STG, therefore, the procedures required for the procedures would also not meet the STG. **No** reimbursement is recommended.
07/13/01 06/01/01 06/01/01 06/29/01 06/29/01 07/13/01 07/13/01	J7040 E0776 A4454 E0776 A4454 E0776 A4454	$20.00 $20.00 $20.00 $20.00 $20.00 $20.00 $20.00	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	T T T T T T T	DOP DOP DOP DOP DOP DOP DOP	STG Rule 134.1001 (e) (2) (A) (i); (e) (3) (G)	STG Rule 134.1001 (e) (2) (A) (i) states, "…treatment of a work related injury must be: adequately documented…" STG Rule 134.1001 (e) (3) (G) reports, "Documentation for…spinal injections should show objective/quantified measures of substantive and continued improvement over time which may include but are not limited to: (i) decreased used of medications; (ii) increased function due to reduction in pain; or (iii) enhances the ability of the employee to return to or retain employment." The provider failed to medically document significant or long term relief, decreased use of medications, increased function due to reduction in pain, or enhanced ability for the employee to return to work. There is no documentation of the claimant's work status or pain status. The daily work hardening notes post injections make no mention of the injections or any results from the injections. As a result, the ESI procedure did not meet the STG, therefore, the supplies and medication required for the procedures would also not meet the STG. **No** reimbursement is recommended.
Totals:		$13,705.00	$300.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 16th day of July 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.